Association News

Policy Statements Adopted by the Governing Council of the American Public Health Association, November 18, 1998

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9801: Meeting Public Health and Epidemiologic Data Needs in a Managed Care Environment

The American Public Health Association,

Affirming that core functions of public health agencies at all government levels include assessment, policy development and assurance, that every public health agency should regularly and systematically collect, assemble, analyze and make available information on the health; and safety of the community, and that seeing that this assessment function is fulfilled is a basic function of public health which cannot be delegated; and[1,2]

Whereas Managed Care Organizations (MCOs) offer a unique opportunity to bring many providers and users together to build databases of members, for use as a proxy for population-based information; knowing MCOs collect three types of data: (1) administrative, (2) enrollment, (3) clinical; and

Noting the importance of data on enrollment, coverage, health status, and utilization of health services data in evaluating access to medical care, recognizing the importance of screening, diagnosis and treatment data in surveillance and prevention of diseases and injuries, and the value of longitudinal outcome data in health services research; and

Recognizes that the shifting of publicly-funded services to managed care providers has meant that the data on persons receiving publicly-funded services may not be readily available and reporting may be a significant problem; Acknowledging these data may lack completeness, validity or appropriateness for public health use; and

Seeking to assure that data for core public health functions are available to governmental public health agencies from public and private sector sources, including managed care organizations and integrated health services delivery systems, at a reasonable cost, and with adequate protections of confidential personal health data; therefore

1. Urges the federal government and the states to take steps to assure that regulation and contracts with managed care organizations require collection and sharing of public health data related to core public health functions, particularly data needed to access health status of whole communities, for disease and injury preparation and control surveillance and for health services research, including health outcomes, utilization of prevention services and cost analyses;

2. Calls on managed care organizations and any organizations with which they contract to participate in population-based registries, sentinel systems, laboratory epidemiologic surveillance programs, disease and adverse drug events reporting, and surveys which provide essential epidemiologic information;

3. Urges public health agencies to provide analysis and feedback from surveys, registries and surveillance to participating managed care organizations in order to enhance quality of care and access to services, supporting quality improvement efforts;

4. Encourages the use of electronic data exchange, standardization of data elements, incorporation of existing data systems, such as vital records, hospital discharge data, and the long-term care Minimum Data Set, rather than the creation of competing systems and development of shared data systems;

5. Urges attention to protecting confidentiality of sensitive personal data to meet local, state and federal standards while ensuring a balance of access to data for quality health care and adequate public health services, but recognizing the need for identifying data in controlling disease, and injury providing enabling services, assuring quality, and conducting needed surveys;

6. Urges public health agencies and managed care organizations to seek efficient means to collaborate on data collection and analysis to support the mission of public health; and

7. Encourage state, local and federal government agencies that contract with the health systems with managed care and integrated health services systems to develop model contract language that included sharing data with public health officials on public health care functions.

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9802: Managed Care and People with Physical/Mental Disabilities

The American Public Health Association,

Understanding that millions of Americans with physical and/or mental disabilities are covered by Medicare, Medicaid, and/or private or some other public insurance;[1] and

Recognizing the growing presence of managed care in the United States in which enrollment in Managed Care Organizations (MCOs) has surpassed 130 million people[2] and 75 percent of all workers now receive their health care coverage through this form of service delivery;[3] and

Recognizing that 15 million Medicaid patients now receive health services through some type of managed care format as states have increasingly adopted this system for their low income populations;[4,5] and

Recognizing that, in 1997, Congress enacted major changes to Medicare that will now offer managed care options on a broad scale to beneficiaries of that program;[6] and

Aware that, as a result of these trends, increasing numbers of people with physical and/or mental disabilities[7] who have traditionally received care through fee-for-service delivery will become covered by managed care companies. As a result, managed care health plans may be unprepared to accommodate the special needs of people with disabilities or may have incentives that adversely affect those in need of expensive or specialized care;[8,9,10] and

Observing that numerous studies and reports indicate significant levels of dissatisfaction with managed care on the part of people with disabilities who enroll in such plans;[11,12,13] and

Noting that recent studies have indicated continuity of care, a critical aspect of care for those with chronic conditions, "may be compromised" in managed care settings and that comprehensive care may fall victim to managed care coverage restrictions and referral limitations;[14] and

Noting that current measures used to evaluate the quality of care provided by managed care plans may not reflect the adverse longitudinal impact of these plans on the quality of care delivered to people with disabilities and chronic illnesses;[15,16] and

Recognizing that, as public accommodations covered by the Americans with Disabilities Act (ADA), managed care organizations are legally obligated to make their services and facilities accessible to people with physical and/or mental disabilities; and

Having previously concluded that managed care organizations must meet high quality standards for accountability, access to services, due process, confidentiality and solvency;[17] therefore

1. Urges Congress, the states and providers to support managed care consumer protections such as those outlined in the Consumer Bill of Rights and Responsibilities issued by the Advisory Commission on Consumer Protection and Quality in the Health Care Industry;

2. Urges the Administration to devote

adequate resources to enforcing the Americans with Disabilities Act as it applies to managed care organizations and their facilities;

3. Urges Congress and the states to strengthen further the rights of health plan enrollees, in particular consumers with physical and/or mental disabilities, by seeking additional measures to assure timely access to specialists for those with complex medical conditions, to ensure compliance with the ADA, provide access to appropriate medical rehabilitation services including home health care and high quality medical equipment and supplies, require appropriate accreditation and board certification for all providers, assure patients' access to their medical records and participation in treatment planning and decision-making, and ensure the availability of a simple and efficient ombudsman system;[18]

4. Urges Congress and the states to fund initiatives to educate managed care providers and administrators about the specific care needs of people with disabilities;

5. Urges the National Committee on Quality Assurance, Joint Commission on Accreditation of Health Organizations, Commission on Accreditation of Rehabilitation Facilities and other sources of quality standards to develop measurements that can be used by consumers to evaluate the quality of care provided by managed care organizations to people with disabilities; and

6. Urges Health Care Financing Administration (HCFA), appropriate state agencies and MCOs to develop and maintain policies on the confidentiality of information and privacy of persons with physical and/or mental disabilities serviced by these health systems.

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9803: Addressing Medicare Waste, Fraud and Abuse

The American Public Health Association,

Observing that the Medicare program is the largest single payer for health care goods and services in the world covering over 38 million beneficiaries at a cost of $197 billion dollars in FY 1996 and that the Medicare program is one of the most vulnerable government programs susceptible to waste, fraud, abuse and mismanagement;[1] and

Responding to the comprehensive Medicare audits for FY 1996 and 1997 that found unnecessary and improper payments to providers in the fee-for-service system totaling more than $23.2 billion or 14 percent and $20 billion or 11 percent respectively, as well as excessive payments for prescriptions drugs,[5] ambulatory services,[2] and other ancillary services; and

Noting that fraud and abuse encompass a wide range of improper billing practices that include misrepresenting or overcharging for services delivered resulting in unnecessary costs to Medicare;[6,7] and

Acknowledging that billing errors and honest misunderstanding of government billing regulations should not be characterized as criminal behavior has been determined that hospitals knowingly submitted fraudulent claims before attempting to prosecute under the False Claims Act; and

Supporting the Inspector General's position that "adoption and implementation of voluntary compliance programs significantly advance the prevention of fraud, abuse and waste"[8] and that compliance programs decrease billing errors; and

Understanding that the Health Care Financing Administration (HCFA) relies primarily on payment safeguards that consist largely of contractors' efforts to detect improprieties both before and after claims have been paid and on complaints contractors receive from beneficiaries to contain fraud and abuse;[9] and

Noting that HCFA has reacted slowly to recommendations to use available technology for claims-auditing systems to detect inappropriate coding/billing that could save Medicare about $600 million dollars per year;[10,11] and

Acknowledging that durable medical equipment (DME)—$6 billion Medicare cost—and home health—$16.9 billion cost—have a special vulnerability to fraud and abuse;[12–14] and

Realizing that until 1997 the HCFA certification process for home health agencies (HHAs) did not screen for potentially fraudulent or abusive billing and that criminal activity was not a deterrent to HHA certification

unless specifically related to Medicare[14] and that a similarly weak certification process was in place for DME providers;[16] and

Acknowledging that Congress through passage of the Kassebaum-Kennedy (HIPAA) legislation in 1996 and the Balanced Budget Act of 1997 provided new resources and tools to fight health care fraud and abuse;[17] and

Appreciating the new initiatives to address fraud and abuse, including Operation Restore Trust (ORT), a comprehensive anti-fraud initiative, and new efforts to produce regulations for HHAs and DME providers as a condition of participation in Medicare;[20] and

Noting that for FY 1997 expanded efforts to fight fraud and abuse in health care produced unprecedented levels of recoveries and prosecutions and has removed about 3,000 'unsuitable' health care providers from Medicare;[20] therefore

1. Urges providers, especially hospitals, to develop effective internal controls (compliance programs) that promote adherence to applicable federal and state law, and the program requirements of federal, state and private health plans;

2. Encourages corporate officers and managers to provide ethical leadership for their health organizations and to assure that adequate systems are in place to facilitate ethical and legal conduct;

3. Recommends that HCFA and appropriate state agencies improve certification and re-certification procedures for home health agencies and DME providers and increase monitoring and oversight (inspections) of home health agencies' compliance with state and federal requirements and quality of care standards;

4. Urges HCFA to implement stronger oversight to ensure provider compliance with Medicare reimbursement rules and regulations and to expedite implementation of commercial claims-editing capability;

5. Urges state and federal governments' increased enforcement of sanctions and penalties for Medicare providers in violation of standards and those involved in criminal activity; and

6. Supports action by HCFA and authorizing legislation needed to lower reimbursement to address issues of overpayment for ambulance services, DMEs and prescription drugs and other ancillary services so as to achieve payments closer to standard industry discount pricing.

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9804: Cessation of Continued Development of Nuclear Weapons

The American Public Health Association,

Recalling that the Governing Council of the American Public Health Association has adopted policy statements calling for a Comprehensive Nuclear Test Ban Treaty (CTBT), an end to the continued development of nuclear weapons, and for the abolition of nuclear weapons;[1,2] and

Noting with approval that the President of the United States on September 23, 1997 submitted for ratification to the US Senate the CTBT that had been negotiated by the United Nations Committee on Disarmament in Geneva, approved by the United Nations General Assembly, and signed in New York City by the United States;[3] but

Noting with severe disapproval that the President in the same transmittal letter to the Senate called for "maintaining our nuclear deterrent under a CTBT through a Science Based Stockpile Stewardship Program[3] at a projected cost of at least $4 billion per year;"[4] and

Noting that the US Department of Energy continues under the Stockpile Stewardship Program to use subcritical nuclear tests, laser simulation, computer-simulation testing, and other non-nuclear-explosive methods to test nuclear weapons with new military capabilities;[5] and

Recalling that the International Court of Justice in its 1996 Advisory Opinion held unanimously that there exists an obligation by the nuclear weapons states under Article 6 of the nuclear Non-Proliferation Treaty "to pursue in good faith and bring to a conclusion negotiations leading to nuclear disarmament in all its aspects under strict and effective international control;"[6] and

Noting that in November 1997 Costa Rica submitted to the Secretary-General of the United Nations a Model Nuclear Weapons Convention, which was circulated as a United Nations document (A/C. 1/52/7); and

Noting with approval the introduction in the US House of Representatives in June 1998 of a Resolution (HR 479) that calls on the President of the United States "to initiate multilateral negotiations leading to the early conclusion of a nuclear weapons convention;" therefore

1. Calls upon the Senate promptly to

ratify the CTBT without any link to the "Stockpile Stewardship" Program or to continued non-explosive nuclear testing;

2. Calls upon the President and the Department of Energy to end the "Stockpile Stewardship" Program, subcritical testing, laser simulation, computer-simulation testing, or other programs that would lead to development of new or "improved" nuclear weapons; and

3. Calls for expeditious progress toward an international treaty to abolish nuclear weapons, as promised in Article 6 of the Nuclear Non-Proliferation Treaty and called for in a unanimous advisory opinion by the International Court of Justice.

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9805: Use of Food Irradiation as an Adjunct to Sanitation and HACCP Procedures to Improve the Safety of the Food Supply

The American Public Health Association,

Recalling its long history of involvement and concern with a safe food supply as evidenced by public policy statements 5404: Control of Trichinosis, 5608: Federal Poultry Inspection, 6009: Compulsary Pasteurization, 6519: Grade A Pasteurized Milk Ordinance and Code, 6923(PP): Meat and Poultry Inspection, 7925(PP): Protection of the Public Against Foods and Beverages That Are Unfit for Human Consumption, and others; and

Realizing that, despite decades of effort to reduce the morbidity and mortality associated with disease caused by foodborne pathogens such as *Campylobacter, Escherichia coli O157:H7, Listeria monocytogenes, Salmonella, and Staphylococcus aureus,* they still cause as many as 9,000 deaths each year and 6.5–33 million cases of diarrheal diseases in the United States.[1,3] *E. coli O157:H7* has achieved particular notoriety in recent years with the outbreak in the northwestern US, with over 700 cases and four deaths, as well as subsequent outbreaks throughout the country and the massive recall of contaminated ground meat from one supplier;[1,3] and

Realizing that the Food Safety and Inspection Service (FSIS), United States Department of Agriculture (USDA), the Food and Drug Administration (FDA), and HHS (Health and Human Services), recognizing the importance of public health prevention, have responded to these concerns by applying to the farm-totaled continuum, the Hazard Analysis and Critical Control Point (HACCP) systems developed by NASA (National Aeronautics and Space Administration) to establish new and expanded performance-based requirements and/or guidance for sanitation and microbial testing for meat,[3] poultry,[3] and fish,[4] fisheries,[4] fruits and vegetables,[5] and fruit juice.[6] These requirements are in the process of implementation in the 1997–2000 time frame and should result in the identification and elimination of many potential points where food products may become contaminated with pathogens and substantially reduce such contamination; and

Recognizing that over 40 years of research, as well as use in the United States (NASA, military, institutional, and public) and in 36 other countries, has demonstrated the effectiveness and safety of treatment of meat,[1,2,7] poultry,[1,7,8] fruit,[1,9,10] vegetables,[1,9] spices,[1,9] fish and shellfish[1] with gamma-or X-rays or electron beams for such purposes as sterilization, cold pasteurization, fumigation, spoilage retardation or control of maturation including inhibition of sprouting[1,2,7–11,18,21] and, in particular, noting that irradiation of food, under the conditions approved by the FDA and the USDA, does not, and cannot, make the food radioactive, does not create biochemical species in food different in kind or quantity from those produced by other means of preservation or cooking, and does not affect the nutritional adequacy of the foods;[1,2] and

Knowing that the US Food and Drug Administration has approved the irradiation of red meat, pork, poultry, fruits, vegetables, spices, dry vegetable seasonings, wheat, and wheat flour for general use, and shelf-stable steak and smoked turkey for use by astronauts and that the USDA has approved regulations for irradiation of pork, poultry, and papaya fruit;[1,2,7–11] and

Believing that radiation pasteurization, when used in conjunction with the HACCP procedures currently being implemented, as well as proper storage, processing and preparation techniques, will reduce the residual pathogen load by four to seven orders of magnitude;[1,2] further reducing the probability that foodborne pathogens associated with meat, poultry, and other foods will reach consumers; and

Further recognizing that the extension of shelf life and reduction of spoilage obtained by irradiation will effectively increase the supply of some foods[20,28] and facilitate their shipment to and availability in parts of the world where they are not currently available or in limited supply; and

Knowing that most medical and surgical supplies and personal care products have been sterilized with radiation for many years (replacing ethylene oxide, a suspect carcinogen)[1] using irradiators, X-ray machines, and electron accelerators like those used for irradiating food; and

Recognizing concerns about occupational, transportation, and environmental issues concerning irradiators, but believing that the designs and conditions of use of gamma rays and other radiation producing machines are adequately regulated and inspected by the Food and Drug Administration,[23] and the various states;[24] and

Acknowledging that food irradiation has been endorsed by the World Health Organization,[1,12,19,21,29] the International Atomic Energy Agency,[1,18,22] the Food and Agriculture Organization of the United Nation,[1,18] the American Medical Association,[1,18] the US Food and Drug Administration,[1,8,10,17,22,28,29] the US Department of Agriculture,[1,2,8,10,14,29] the UN Joint Expert Committee on Wholesomeness of Irradiated Food,[1,12,18] the Codex Alimentarius Commission,[1,18,21] and many other medical and scientific societies and commissions[1,18,28,29] and has been authorized for use by the governments of 37 countries,[1,18] therefore

Knowing that food irradiation alone cannot assure a safe food supply and that traditional food safety measures such as proper food handling and preparation; therefore

1. Endorses the use of food irradiation, under conditions approved by the Food and Drug Administration, HHS and the Food Safety and Inspection Service, USDA, and using electronically generated radiation in conjunction with the recently revised sanitation

requirements (HAACP) and performance testing to further improve the safety of the food supply;

2. Urges the USDA promptly to issue regulations for the irradiation of red meat and any other food product that has been approved by the FDA for radiation treatment; and

3. Urges that existing safe food methods such as good manufacturing practices and safe handling and preparation procedures continue to be emphasized and that the FDA and USDA develop a comprehensive and coordinated public health education campaign about food irradiation and distribute informational literature on these issues.

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26. Each state has radiation control regulations based on federal and international standards. Except for federal installations, regulation and inspections of X-ray machines and accelerators are done by states. c/f PA Code 25 (Environmental Protection), Article V (Radiological Health), Chapters 215 (General Provisions), 216 (Registration of Radiation Producing Machines, 219 (Standards for Protection Against Radiation), 220 (Notices, Instructions and Reports to Workers; Inspections) and 228 (Radiation Safety Requirements for Particle Accelerators).
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9806: Preventing Adverse Occupational and Environmental Consequences of Methyl Tertiary Butyl Ether (MTBE) in Fuels

The American Public Health Association,

Recognizing that Methyl Tertiary Butyl Ether (MTBE) is an oxygenate that boosts a fuel's oxygen content and that MTBE has been the gasoline additive of choice for the US oil industry since the US Congress mandated the addition of air-cleaning chemicals to gasoline in 1990;[1] and

Recognizing that MTBE is currently a $3 billion per year commodity in the US and cur-

rently makes up 11% of most gasoline sold in California by volume, and 31% of all US gasoline contains MTBE;[2] and

Recognizing that MTBE causes cancer in mice[3] and rats[4] and has the potential to be a carcinogen in humans;[5] and

Recognizing that MTBE is exhausted into the air, emitted into lakes and rivers by recreational motorized vehicles, and is leaking into water from tens of thousands of underground storage tanks. MTBE has been found in 3.4% of water districts tested in California, with highest levels found in Santa Monica, California where 50% of its drinking water wells were shut down due to MTBE contamination;[3] and

Understanding that exposure levels near gasoline pumps reach 1,500 parts per billion (ppb) in states without vapor recovery systems, and 245 ppb in states like California with vapor recovery systems, resulting in levels of MTBE in blood of gasoline service station attendants of 7.6–28.9 micrograms/l;[6] and that human health effects including difficulty breathing, headaches, nausea, rashes, nosebleeds, eye irritation and dizziness have been reported by drivers, gas station attendants and refinery workers exposed to gasoline containing MTBE;[5] and

Understanding that the effectiveness of MTBE in reducing carbon monoxide is disputed, and that other more reasonable alternatives, such as reformulated gasoline, can be just as effective at reducing carbon monoxide and other pollutants without MTBE as with it;[7] and that other similar oxygenates including ether compounds or heavy metal gasoline octane booster additives such as manganese[8] also pose unacceptable environmental and occupational health risks; and

Recognizing that some oil refining and distributing companies have already removed MTBE from their fuels, relying instead on reformulated fuels and ethanol-containing fuels;[9] and

Recognizing that some municipal utility districts have already planned phase outs of the use of powerboats on lakes in the US due to concern about MTBE in drinking water sources;[10] and

Recognizing that APHA policy already has called on Congress to insure that adequate scientific studies are conducted on oxygenated fuels, including MTBE, and, pending completion of such studies, delay in imposition of Clean Air Act Sanctions on states such as Alaska;[11] and

Recognizing the precautionary principle which was endorsed by prior APHA policy[12] that states that "where there are threats of serious or irreversible environmental damage, lack of full scientific certainty shall not be used as a reason for postponing cost-effective measures to prevent degradation"; therefore

1. Recommends that the US Environmental Protection Agency ban the use of MTBE (as the EPA previously has done for other unacceptable hazardous chemicals such as Polychlorinated Biphenyls) or other similar ethers from use as an oxygenate for fuels, and consider mandating safer and tested reformulated fuels, such as currently required in California; and

2. Recommends that water districts and other units of government consider bans on the use of gas-powered motors on lakes and rivers where their use adversely affects sources of drinking water.

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9807: Preventing Adverse Environmental Effects and Safety Hazards of "Light Trucks"

The American Public Health Association,

Recognizing that "Light Trucks" include sport utility vehicles, pickups and minivans, which have become the most commonly sold motor vehicles sold in the US;[1] and

Recognizing that light trucks, including sport utility vehicles, are subject to much more lenient regulation in terms of required gasoline mileage (20.7 miles per gallon, compared with 27.5 miles per gallon for the average automobile) and emit higher levels of air pollutants than automobiles, including up to five times the amount of oxides of nitrogen and carbon dioxide,[2] and are expected to contribute 34% of the increase in total energy-related carbon dioxide emissions from 1990–2010[3] resulting in a slowing of progress toward cleaner air in US cities and threatening the US pledge to reduce overall carbon dioxide emissions to 1990 levels by 2010; and

Recognizing that light trucks are exempted from the gas-guzzler and luxury vehicle tax; domestic pickup trucks are protected from foreign competition by a 25% federal tax on imported pickup trucks, resulting in a reduced competitive incentive to develop more fuel-efficient trucks; and people who use light trucks on the job are able to claim higher tax deductions than people using cars for work; and

Recognizing that light trucks, including sport utility vehicles, pose safety hazards to occupants of these vehicles as well as other vehicles[4] because they tend to roll over more easily than automobiles, and due to their average 1/2 ton additional weight (4000 lbs. vs 3000 lbs. average for automobiles), and higher ride, light trucks inflict heavy damage to other vehicles in collisions, resulting in more deaths in 1996 due to automobile-truck collisions than automobile-automobile collisions despite the fact that there were only 1/2 as many trucks as cars in the US in 1996.[3] Federal safety standards for brakes on light trucks are more lenient than cars. Light trucks are required to be able to stop from 60 mph within 216 feet vs 204 feet for cars. Due to their size and shape, light trucks pose additional hazards by causing reduced visibility for drivers attempting to see around them, for example, while backing out of a driveway or entering a roadway near where they are parked; and

Understanding that the Association has previously endorsed prevention as the primary premise for controlling and managing air emissions which are reasonably anticipated to pose hazards to human health and the environment;[5] and

Understanding that the Association has previously encouraged development of appropriate public health measures for improving the protection of occupants of automobiles, vans and light trucks;[5] therefore

1. Recommends that the US Congress regulate light trucks' gasoline mileage and vehicle emissions at least as strictly as for automobiles, and eliminate the preferential tax incentives for purchase and operation of light trucks;

2. Recommends that the US Congress require crash tests by automakers to prove that any new light trucks do not inflict excessive damage on existing vehicles during collisions;

3. Recommends that light trucks be redesigned to reduce their overall weight and height and to reduce their likelihood of inflicting serious injury on automobiles;[7]

4. Recommends a minimum standard of half-track width divided by center of gravity height of 1.2 or higher be required of all light passenger vehicles; and

5. Recommends that National Highway Traffic Safety Administration (NHTSA) increase side-impact standards in light trucks and passenger vehicles under 8,000 pounds to provide greater safety.

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9808: National Tobacco Control Legislation

The American Public Health Association,

Acknowledging that the detrimental effects of tobacco use have long been known to have a severe, negative impact on the public's health;[1] and

Recognizing that comprehensive, well-funded, sustainable national tobacco control legislation is crucial to achieving long-term reductions in the prevalence of smoking by youth and adults;[2] and

Reaffirming the long-standing policies of the American Public Health Association in support of strong tobacco control actions to protect the public's health (APHA Public Policy Statements 1948–present, Cumulative, American Public Health Association, Washington, DC); therefore

1. Congratulates President Clinton and the Koop-Kessler Committee on initiating tobacco control efforts in 1997 by their (a) review of the national tobacco control proposal; (b) call for unfettered authority of the Food and Drug Administration (FDA) to regulate nicotine and all tobacco products; (c) emphasis on the importance of tax and price increases on all tobacco products to deter smoking by young people; and (d) call for a properly designed national tobacco control policy;[3]

2. Recommends that legislation for a national tobacco control policy be developed that meets five basic principles: (1) protection of children against inducements to use tobacco and encouragement not to use it;[4] (2) aid to addicted adults and children in cessation of tobacco use;[5] (3) right of every person to breathe air not contaminated by tobacco smoke;[6,7] (4) the same right of parties injured by tobacco to sue for compensation as they have with other products;[8] and (5) require meaningful community-driven strategies for stabilizing the economies of tobacco-dependent communities;

3. Recommends that national tobacco control legislation (a) ban all advertising, promotion, and sponsorship of tobacco products;[9] (b) substantially and repeatedly raise the tax on cigarettes and other tobacco products;[10] (c) require the tobacco industry immediately to implement strengthened health warnings stating that tobacco is addictive, causes heart disease and cancer, and can kill; (d) reaffirm the full authority of FDA to regulate nicotine as an addictive drug and all tobacco products as drug delivery devices,[11] (e) require a large comprehensive sustained professionally designed anti-tobacco education program and well-designed cessation programs and quality assurance mechanisms funded, but not controlled by, the tobacco industry;[12] (f) require the complete public disclosure of all tobacco industry documents that relate to the development, promotion and sale of tobacco products and/or the health consequences of tobacco products;[13] and (g) require that all tobacco products be fire-safe;[1] and

4. Specifically recommends that national tobacco control legislation neither preempt any state or local authority from further regulating tobacco nor grant the tobacco industry immunity from liability.[14]

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9809: An International Tobacco Control Policy

The American Public Health Association,

Recognizing that tobacco use is a growing threat to public health world-wide and accounts for 3 million deaths each year;[1] and

Recognizing further, that if present smoking patterns persist, 10 million people will die each year from tobacco use by the time the children of today reach middle age, 3 million in developed countries, 7 million in developing countries;[2] and

Noting that in 1997, Congress enacted an amendment to the Commerce, State and Justice appropriations bill prohibiting the use of government funds to promote tobacco sales or exports overseas and prohibiting the Departments of Commerce, State and Justice from seeking to weaken the tobacco control laws in any country;[3] and

Noting further that legislation has been introduced in Congress but not passed that would require that American tobacco companies abide by the same rules regarding sales to minors, marketing, and health warning labels in their international operations as they do in the US and requiring that health warning labels be in the primary language(s) of the country in which the products are sold;[4] and

Noting further that on July 9, 1997 the report of the Koop-Kessler Advisory Committee on Tobacco Policy and Public Health, formed at the request of a bipartisan group of members of Congress, including Congressperson Waxman, addressed the omission of international tobacco policy;[5] and

Concerned that the aggressive marketing and promotion of tobacco in developing and transitional nations by American tobacco conglomerates has an adverse impact on the health of all populations abroad, particularly women and children; and

Concerned that the United States government has contributed to the growth of the global tobacco pandemic by promoting the transnational activities of American tobacco conglomerates;[6] and

Reaffirming the long-standing policies of the American Public Health Association in support of strong tobacco control actions to protect the public's health;[7] therefore

1. Recommends that activities and legislation for an international tobacco control policy be developed that meet four basic principles: (1) the United States should actively promote global tobacco control; (2) the United States should assure that public health concerns overrule trade considerations in all trade regulations and related proceedings; (3) the United States should actively support and allocate substantial resources to fund effective international governmental and non-governmental institutions engaging in tobacco control activities; and (4) the United States should effectively regulate the activities of American-based tobacco conglomerates to support these global tobacco control efforts;

2. Specifically recommends that tobacco control legislation should (a) remove tobacco products from Section 301 of the 1974 Trade Act, which grants broad discretionary powers to impose trade sanctions against any nation whose trade policies are "unjustifiable, unreasonable or discriminatory" and under which several Asian nations have been forced to open their markets to US tobacco products and tobacco advertising; (b) prohibit federal agencies from promoting American tobacco products abroad, or interfering in any efforts by international or foreign public health authorities to control tobacco use within their sovereign borders; (c) require that US tobacco exports contain the same warning labels of equal size in the local language as are required by law in the United States; (d) provide for the surveillance and prevention of international tobacco smuggling, including strict penalties for companies shown to be supporting smuggling; and (e) require that all tobacco products be fire-safe; and

3. Specifically recommends that the United States adopt legislation that requires every US tobacco company to pay at least a 2-cent fee for each package of cigarettes it sells overseas, with the money raised from such fee to be used by governmental and non-governmental entities for international tobacco control activities, including (a) the promulgation and implementation of the World Health Organization Framework Convention on Tobacco Control;[8] (b) efforts by United Nation's Children Fund (UNICEF) to promote eradication of tobacco use among children; and (c) efforts by all appropriate federal agencies, including Health and Human Services, to promote tobacco control internationally.

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9810: Health Services for American Indians and Alaska Natives

The American Public Health Association,

Noting that the 1990 US Census Bureau reports that reservation-based Indian populations have fewer economic and educational opportunities than the rest of US society, partly due to the remoteness and isolation of many of their communities;[1] and

Finding that American Indians and Alaska Natives health status is lower than the general US population due to poor nutrition compounded by unsafe water supplies, and inadequate waste disposal facilities and that they experience a higher incidence of otitis media, heart disease, alcohol and drug problems, chronic liver disease, mental health problems, diabetes, oral disease,[13,14] obesity,[15,16] and injuries;[2] and

Recognizing that American Indians and Alaska Natives are citizens of their Tribes, their states and the United States of America and that the Tribes are governments with the inherent right to govern themselves; and

Affirming that the Federal responsibility for American Indian/Alaska Native health care is grounded in treaty obligations, case laws, the Snyder Act of 1921 (PL 83-568), the Indian Health Care Improvement Act (PL 94-437), as well as historical obligations;[3] and

Confirming that the Federal government has a special "trust responsibility" that entitles federally recognized Tribes to participate in federal financial programs and other services, such as education and health care; and

Observing that approximately 1.34 million American Indians and Alaska Natives belong to the more than 545 federally recognized tribes and qualify for Indian Health Services and Bureau of Indian Affairs services; and

Acknowledging that in keeping with the concept of tribal sovereignty, the Indian Self-Determination and Educational Assistance Act (PL 93-638) of 1975, as amended, gives Tribes the option of staffing and managing Indian Health Service programs in their communities, and provides for funding for improvement of tribal capability to contract or compact under the Act; and

Noting that the relationship between the Indian Health Service and the Tribes has been defined through an extensive and exhaustive process conducted by the Indian Health Design Team;[5] and

Realizing that the public health responsibilities for American Indians and Alaska Natives must be addressed at both the National and Tribal level and that the entire public health apparatus, including federal, state, county, municipal, and Tribal health organizations, is jointly responsible;[6] and

Understanding that the Tribe has ultimate responsibility for the majority of public health activities and will decide whether to accomplish alone, by contract or compact, by agreement with another agency, or by other collaborative arrangement; and

Maintaining that Tribes are and must be the central force in public health programs for American Indian and Alaska Natives and that each sovereign Tribe has the independent authority to determine their own standards and measures, set public health priorities, and carry out public health functions;[7] and

Knowing that the provision of health care to American Indians and Alaska Natives in Indian country and urban areas has become increasingly complex and even with increased flexibility in use of health care dollars these dollars are becoming less available;[8] and

Recognizing that Congress has encouraged the Indian Health Service to carry out their responsibility using three distinct delivery systems, the Indian Health Service direct hospitals and clinics (I), the tribally operated health programs, services and facilities (T), and the urban Indian health programs(U); and

Finding that the President's Budget for Fiscal Year 1999 amounts to only a one percent increase ($19.7 million) in the Indian Health Service's budget well below the projected 3.5 percent medical inflation rate and that the current level of Indian Health Service funding is only meeting 36 percent of the health need;[9] and

Observing that the inflation adjusted per capita Congressional appropriation for the Indian Health Service has declined from $1,442 in Fiscal Year 1993 to $1,183 in Fiscal Year 1998, an 18 percent decline in real spending,[10] and that the Indian Health Service appropriation in Fiscal Year 1997 was less than 34 percent of the per capita expenditure for the civilian US population for medical care;[11] and

Acknowledging that the National Indian Health Board, the National Congress of American Indians, the Tribal Self-Governance Advisory Committee and the National Urban Indian Health Council are advocating for a $419 million increase, including at least a $110 million increase in Contract Support Costs, in the Fiscal Year 1999 Indian Health Service budget based upon a comprehensive tribal formulated budget process; and

Believing that no American Indian or Alaska Native from any Tribe, no matter how small or remote, should be without identifiable and realistic access to the benefits of health care and public health protection.

Therefore based on culturally appropriate considerations:

1. Reaffirms that the federal government of the United States of America has a trust responsibility for American Indian/Alaska Native health care grounded in treaty obligations, case law, the Snyder Act of 1921 (PL 83-568), and the Indian Health Care Improvement Act (PL 94-437), as well as historical obligations;

2. Recommends that the Indian Health Service retain capacity for assessing changing health needs of Indian people, determining the amount of resources that are needed to address those needs, and assisting the Indian Health Service direct hospitals and clinics, the tribally operated hospitals and clinics, and the urban Indian health programs, as requested, to develop effective strategies to meet those needs;[12]

3. Urges the public health community, including state and local agencies, and Tribes to build mutually collaborative working relationships to improve and promote public health for all American Indians and Alaska Natives;

4. Urges the public health community to recognize, honor, and respect Tribal beliefs and practices to promote public health education and training with Tribes to improve access to information, practice, and standards;

5. Encourages Tribes to improve their public health capabilities through staff development and training, high prioritization of funding for public health programs/services, and appropriate technical assistance arrangements;

6. Supports efforts to assure that American Indians and Alaska Natives from all Tribes should have identifiable and realistic access to the benefits of public health protection;

7. Endorses significant increases in Indian Health Service funding levels to continue support for health care improvement, self-determination and the technical assistance needed to support both efforts in the true spirit of Tribal sovereignty, consistent with the recommendations of the Indian Health Design Team;

8. Urges States to develop relationships with Tribal health entities to improve capacity and capabilities and to support these improvements with additional funding support; and

9. Supports and encourages the continued development of the I/T/U concept as a means of implementing the federal government's obligation for health care for American Indians and Alaska Natives.

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9811: Health Services for Urban American Indians and Alaska Natives

The American Public Health Association,

Observing that more than half[1] of the approximately 2.3 million American Indians, and Alaska Natives live in United States cities; and

Noting that many urban American Indian and Alaskan Natives depend upon Indian-operated urban programs for access to health services ranging from information referral and community health services to comprehensive primary health care services;[9]

Realizing that Congress authorizes funding for these urban programs through Title V of the Indian Health Care Improvement Act, a separate and distinct program from other Indian Health Service Appropriations;[10]

Recognizing that American Indian and Alaska Natives living in cities do not share equitably in assistance granted Indian people who remain on Indian reservations;[11]

Acknowledging that urban American Indians/Alaska Natives like their reservation counterparts, are disproportionately affected by serious health problems such as diabetes, heart disease, stroke, unintentional injuries, suicide, homicide, and alcohol and drug problems, obesity,[12–13] oral diseases,[14–15] mental health problems, and infant mortality;[2] and

Knowing that the health of American Indian and Alaska Native people, while improving, continues to lag behind other Americans;[3] and

Noting that the health status of urban American Indians and Alaska Natives has been shown to be similar to that found among those living on reservations;[4] and

Recognizing that poverty, unemployment, inadequate education, and other social and economic factors play an important role in influencing the health status of both reservation and urban Indians;[5] and

Acknowledging that federal health care funding for American Indians and Alaska Natives residing in urban areas is seriously inadequate;[6] and

Finding that culturally-sensitive services for urban American Indians and Alaska Natives remain limited due to a lack of Federal, state, and local appropriations and support;[7] and

Recognizing that due to a lack of adequate funding and poor integration with the Indian Health Service programs, that data regarding urban Indian health are severely lacking; therefore

1. Recommends that the Congress of the United States increase appropriations to the Indian Health Service to address the health care needs of urban American Indians and Alaska Natives;

2. Encourages the Indian Health Service with the assistance of American Indian and Alaskan Native community members to promote collaboration between urban programs and tribes to help build bridges between urban and tribal providers;

3. Calls upon state and local health care officials to recognize the unique health care needs of and demonstrate a cultural sensitivity to urban American Indians and Alaska Natives and the importance of including them in efforts to improve access to care and in addressing risk factors contributing to their health problems;

4. Recommends that state and local governments provide complementary funding to assure adequate levels of culturally-appropriate health care for American Indians and Alaska Natives living in their states, cities and counties;

5. Encourages managed care organizations to become culturally sensitive to American Indian and Alaska Native populations, educate these populations on access to the managed care system; and contract with urban Indian health programs as essential community providers;

6. Encourages Indian Health Service facilities to collaborate and partner with urban Indian health programs in their areas to increase access to services for urban Indians; and

7. Recommends that funding be made available to existing urban Indian health programs, to collect and analyze national data specific to urban Indian health for planning and policy development.

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9812: Diabetes among American Indians, Alaska Natives, and Native Hawaiians (AI/AN/NH)

The American Public Health Association,

Recognizing that diabetes mellitus is a common health condition accounting for 10 percent of internist visits and $100 billion in direct and indirect costs annually or 17 percent of all health care costs[1] and that almost 16 million Americans have diabetes, a third of them undiagnosed;[2] and

Realizing that diabetes is the seventh leading cause of death in the United States, and more than 187,000 men, women, infants and children died from the disease and its complications in 1995;[3] and

Acknowledging that diabetes and its complications are major contributors to morbidity and mortality in all Native American populations, except for isolated Arctic groups;[4] and

Observing that the diabetes mortality rates are reported to be 2.7 times higher in the American Indian and Alaska Native population than the population at large[5] and when these mortality rates are adjusted for Native American heritage underreporting, the mortality rate is 4.3 times that of the white population;[6] and

Finding that Native Hawaiians have a diabetes prevalence rate of 5.6 percent compared to 2.7 for Caucasians in the state of Hawaii and that this prevalence rate is an understatement of the actual rate due to socio-economic factors;[7] and

Concerned that American Indians and Alaska Natives have a higher relative risk of diabetes than other groups of Americans (40 as compared to 2.5 for Blacks and Hispanic populations[8]) and that they are more likely to suffer from blindness, renal disease, other health problems associated with microvascular disease; and

Knowing that prevention, early detection, improved delivery of care, and diabetes self-management education can help prevent gestational diabetes or delay the onset of the progression of eye, kidney and nerve damage, gangrene, lower extremity ulcerations, amputations, and other complications;[9] and

Noting that the United States Congress has taken action to address the disparity in diabetes rates for American Indians/Alaska Natives through the Balanced Budget Act of 1997 with an appropriation of $30 million per year for five years for expanded and more intensive diabetes prevention and treatment services in partnership with Tribes and Urban Indian Health programs; and

Acknowledging that the Balanced Budget Act of 1997 appropriation will begin to address the disparate need, but is not sufficient to resolve the disparity; therefore

1. Commends the Congress and the Administration for its decision to appropriate funding specifically to address diabetes among American Indians and Alaska Native men, women, infants, and children;

2. Encourages additional diabetes-related funding support directed to AI/AN/NH until the disparity in mortality and morbidity is eliminated;

3. Supports the development of health services and programs for prevention, early intervention, improved care delivery, and diabetes self-management education to serve the AI/AN/NH community;

4. Encourages partnerships among American Indian, Alaska Native, Native Hawaiian providers, the Indian Health Service, the Centers for Disease Control and Prevention (CDC), state and local health agencies, and service, civic, academic, and research institutions both public and private to prevent, manage and treat diabetes through information sharing, communications, technical assistance which shall include native researchers and culturally appropriate considerations;

5. Supports research activity dissemination to all AI/AN/NH health programs and providers via Indian Health Service and CDC cooperative agreements to ensure access to and availability of primary, secondary, and tertiary prevention research; and

6. Supports data collection, evaluation design and implementation activities of the AI/AN/NH health programs to demonstrate their impact and determine the merits of interventions in preventing and managing diabetes and its sequelae, while ascertaining unique measures developed and applied in AI/AN/NH communities and their applicability to other populations.

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9813: Human Rights in the Curricula for Health Professionals

The American Public Health Association,

Being cognizant that human rights provide the ethical framework for public health practice; and

Noting that respect for human rights, nationally and internationally, requires a legal and ethical framework that includes enforcement and other mechanisms;[1] and

Recognizing that human rights refers broadly to those rights, freedoms, and privileges articulated within the Universal Declaration of Human Rights, and subsequent international, regional, and national agreements, declarations, charters, and laws, including the right to health; and

Noting that human rights violations have direct effects on people's health and quality of life;[2-4] and

Noting the long history of persecution of and discrimination against people with mental and physical disabilities in many cultures; and

Acknowledging that human rights conventions have implications for health and health professionals;[5-7] and

Further acknowledging that the right to the highest attainable standard of health is one of the fundamental rights of every human being;[8-11] and

Concluding that public health and other professionals must be knowledgeable about human rights;[12,13] and

Being concerned that few universities currently include human rights training in their curricula for health professionals;[14] therefore

1. Encourages schools and educational programs in the health professions to make human rights a fundamental component of their curricula; and

2. Recommends that schools and educational programs in the health professions be encouraged to teach human rights together with ethics and health law necessary for the practice of public health that respects and fosters human rights for the betterment of people's health and quality of life.

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9814: Preservation of Reproductive Health Care in Hospital Mergers and Affiliations with Religious Health Systems

The American Public Health Association,

Noting the October 14, 1997 article carried in the *New York Times* entitled, "Catholic Hospitals in Non-sectarian Merger Deal Sets Off Abortion Concerns," regarding the merger of two non-sectarian hospitals in New York State with a third, Catholic hospital, in which, in accordance with Catholic principles, all three of the hospitals will be prohibited from offering many reproductive health services;[1] and

Reaffirming the long standing position of the American Public Health Association that access to the full range of reproductive health services, for women, men, and adolescents is a fundamental right;[2] and

Noting that in 1996, 5 out of the 10 largest health systems in the United States were Catholic, and that ownership or management of group practices by Catholic health systems increased 43% over the prior year;[3] and

Noting that Catholic health systems are governed by the Religious and Ethical Directives for Catholic Health Care Services which prohibit contraception counseling and devices, distribution of condoms, even to prevent the spread of AIDS (acquired immunodeficiency syndrome) and sexually transmitted diseases, tubal ligations and vasectomies, almost all forms of assisted reproduction technology, emergency contraception for rape victims unless they are first tested for pregnancy, and abortion;[4] and

Noting that the Ethical Directives require that when a merger or affiliation between a Catholic hospital and a non-sectarian hospital occurs, the non-sectarian hospital and staff must also abide by Catholic principles;[5] and

Noting that the implementation of religious restrictions on health care often results in women's health being marginalized and relegated to alternative treatment sites where women may be subjected to harassment and clinic violence, and, in the case of the refusal to provide tubal ligations, to unnecessary second procedures and hospitalizations;[4] and

Alarmed that religious control of access to healthcare could prevent the distribution of condoms to control the spread of AIDS and sexually transmitted diseases, or that prohibitions against contraception, sterilization, and abortion could result in an increase in unintended pregnancies or birth;[7] and

Recognizing that managed care plans that are religiously controlled or that contract with religiously controlled hospitals and health facilities can severely undermine access to reproductive health services that patients want, need, and are entitled to have; and

Concerned that, despite the fact that Federal Medicaid funding covers all medically approved methods of birth control, condoms for control of AIDS, and sterilization,[8] and that some states are limiting access to reproductive health services by contracting with religiously controlled managed care systems and hospitals that deny low-income women these services;[8] therefore

1. Urges states, medical associations, hospital associations, unions, and agencies and members of government to oppose any policy that results from a merger or affiliation between religious and non-sectarian health systems that would create obstacles that prevent women, men, and adolescents from receiving the full range of reproductive health services they need;

2. Urges opposition to any policy that results from a merger or affiliation between religious and non-sectarian health systems that would prevent women, men and adolescents from receiving and understanding full and comprehensive information about all the reproductive health choices that should be available to them;

3. Urges that policies be developed and implemented to ensure that health systems that do not perform abortions are required to provide timely and appropriate referrals to qualified providers;

4. Urges states, medical associations, hospital associations, unions, and agencies and members of government to develop and implement protocols for emergency rooms that ensure that all victims of sexual assault have timely, dignified, and appropriate access to emergency contraception;

5. Urges opposition to global conscience clauses that allow entire health care delivery systems to refuse to provide certain health services, but affirms that conscience clauses are respected when tailored to individual provider beliefs, and urges that health systems be required to provide alternate access to the necessary services including voluntary sterilization;

6. Urges Congress and states to protect communication between healthcare providers and their patients to ensure that corporate practices, including religious beliefs, are prohibited from interfering with providers' giving their patients full and accurate information about all health choices;

7. Urges Congress to mandate that comprehensive reproductive health care when federally funded continues regardless of changes in business arrangements or practices;

8. Recommends that state Medicaid agencies and agencies that regulate private insurance allow contracts only with providers who provide the full range of reproductive health services including

a. provision of timely, dignified, and appropriate arrangements for all clients, including low-income clients and

b. provision of comprehensive information about all the reproductive health choices available; and

c. provision for continuity of reproductive health services either by the provider directly, or utilizing unrelated but affiliated institutions in cases where direct provision of reproductive health care is limited by religious prohibitions;

9. Urges regulation by the Department of Justice, State Health Departments, and Attorneys General that ensures full public scrutiny and accountability to the public every time there is a proposed health system merger or affiliation including those between two or more non-profit systems; and

10. Urges managed care plans to refer to providers who provide comprehensive reproductive health services.

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9815: Impact of Police Violence on Public Health

The American Public Health Association,

Recognizing that most law enforcement officials perform their duties in a professional manner, but that police brutality and excessive use of force,[1-5] are widely reported and have disproportionate impact on people of color; [1,4,5] and

Knowing the significant morbidity and mortality associated with many of these events;[1] and

Further noting recent federal legislation to add 100,000 more police to the current force, thus potentially increasing the incidence of injury producing events; and

Recognizing the lack of systematically collected public health data documenting episodes of police brutality,[5] even though Section 21042 of the Violent Crime and Law Enforcement Act of 1994 requires the Attorney General to "acquire data about the use of excessive force by law enforcement officers" and to "publish an annual summary" of these data;[5,6] and

Noting the chilling effect of police violence on the inevitable and appropriate protest by victims of recent reductions or eliminations of social programs; and

Knowing the erratic enforcement of existing guidelines and standards in the control of police brutality;[1] and

Recognizing that public disclosure and independent community review may help expose and reduce the harmful effects of police brutality and excessive use of force;[4,7] and

Further noting the key role played by primary care and emergency health personnel in reporting incidents of police brutality resulting in adverse health consequences; therefore

1. Urges that local, state and federal statistics on the incidence and health consequences of police violence be collected and monitored by public health personnel;

2. Urges that Congress fund the National Institute of Justice and the Centers for Disease Control and Prevention to conduct research and surveillance on the health consequences and prevention of police violence, particularly exploring the disproportionate burden of morbidity and mortality among people of color and immigrant populations;

3. Urges that all localities establish independent community-based review boards to

consider all complaints of police brutality and excessive use of force;[4,7]

4. Encourages health and mental health personnel and organizations to report episodes of police abuse of force and violence to criminal justice authorities and independent community-based review boards, and that legal statutes provide protection against recrimination for such reports;

5. Urges the training of health and mental health personnel in the identification of victims of police brutality and in appropriate means of reporting such events;

6. Urges jurisdictions to strictly enforce police guidelines and international human rights standards, with strong disciplinary measures, and, where appropriate, criminal prosecutions, for the abusive use of force and firearms;

7. Urges jurisdictions to investigate and when appropriate to prosecute incidents of police brutality as hate crimes;

8. Urges that all investigations of police brutality and excessive use of force have full public disclosure after their conclusion, unless criminal proceedings would be jeopardized; and

9. Urges jurisdictions to provide antiracism training in continuing education of all law enforcement personnel, to include the promotion of racial harmony, cultural diversity, and non-violent and non-abusive approaches to their duties.

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9816: Aid to the People of North Korea

The American Public Health Association,

Noting that North Korea suffered devastating floods in 1995 and 1996, followed by a severe drought, a typhoon, and a tidal wave in 1997, that resulted in loss of nearly a million acres of land, crop failures, food shortages, malnutrition of children, and famine among large sections of the population;[1] and

Noting that these natural disasters were associated with severe economic problems exacerbated by US sanctions under the Trading with the Enemy Act banning American companies from doing business in or with North Korea, which have contributed to the desperate shortage of essential drugs, medical supplies, and replacement parts for medical equipment in hospitals and clinics;[2] and

Noting that in 1998 the newly elected President of South Korea, Kim Dae Jung, has called for easing a half-century of enmities on the Korean Peninsula and for an end to sanctions against North Korea by the United States and other western countries;[3] and

Noting that the American Public Health Association has long been concerned with problems of international health in general and with emergency medical aid to relieve the ravages of disease and hunger in particular;[4] therefore

1. Urges the President of the United States and the US Congress to expand significantly current aid activities to relieve the dire conditions of the people of North Korea by providing vaccines, antibiotics and other essential drugs, medical supplies, including parts for X-ray machines and X-ray film, laboratory supplies, and other needed items for emergency services and primary health care;

2. Calls on the American Red Cross and other voluntary organizations and on specialized agencies of the United Nations, particularly the World Health Organization, UNICEF, and the Food and Agriculture Organization, to provide urgently needed medical and food aid;

3. Urges the governments of South Korea and North Korea to cooperate fully with international aid agencies to assure the prompt, equitable, and complete delivery of food and medical supplies to the North Korean people; and

4. Urges the shift of resources in North and South Korea from military priorities to human needs.

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9817: Arms Trade Code of Conduct

The American Public Health Association,

Recalling that the Governing Council of the American Public Health Association has adopted a position paper on "The Health Effects of Militarism" that recognized "militarism as a serious public health problem;"[1] and

Recognizing that the United States is by far the largest international purveyor of arms among the nations of the world;[2] and

Noting that, for example, in 1995, exports of "conventional" arms to the developing world totaled over $21 billion, with the majority of such weapons sold to undemocratic governments;[3] and

Recognizing that an Arms Trade Code of Conduct was introduced into both Houses of the US Congress in 1997 that would have made governments ineligible for US arms and training if the President determines that they are not democratically elected, do not have civilian control of their armed forces, or violate human rights; and

Recalling that the US House of Representatives adopted the Arms Trade Code of Conduct in June 1997 but the US Senate failed to act during 1997 and the Code was not adopted; and

Observing that this Code of Conduct is consistent with an international campaign launched in 1997 by 15 past winners of the Nobel Peace Prize, including Oscar Arias, the Dalai Lama, and Jose Ramos-Horta; and

Noting that the European Union in May 1998 adopted a similar Code of Conduct on Arms Exports; therefore

1. Urges the US Congress to adopt the Arms Trade Code of Conduct; and

2. Urges the President of the United States in the interim to prevent the sale of arms to governments that do not meet the criteria in the code.

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9818: Handgun Injury Reduction

The American Public Health Association,

Recognizing that handgun deaths and injuries—including suicides, suicide attempts, homicides, assaults, and unintentional shootings—constitute a major public health problem in the United States;[1-20] and

Noting that the United States long history of weak federal gun laws and widely varying state and local laws has allowed a vast illicit gun market to flourish, greatly hindering gun violence prevention efforts;[21] and

Understanding that the United States lacks a comprehensive licensing and registration system which would help to curtail the movement of handguns into the illegal market;[22-23] and

Recognizing that the collection and analysis of detailed information about handgun injuries and the movement of handguns in the population is essential to the design and evaluation of injury prevention interventions;[24-25] and

Acknowledging that handguns are the only consumer product made or sold in the United States, other than tobacco products,[1] the manufacture and design of which is not regulated by any federal agency;[26] and

Recognizing that handgun manufacturers, in the absence of any regulatory requirements, have failed to incorporate into the design of their products feasible, life-saving safety improvements which would prevent the discharge of handguns by any unauthorized user, thereby greatly reducing the number of deaths of and injuries to children in suicides and unintended shootings and the attractiveness of stolen and illegally acquired handguns;[27] and

Acknowledging the lack of public awareness of the danger of guns at home and that a gun in the home[28] is much more likely to be used to kill a family member or friend than to be used in self-defense;[29] and

Understanding that the prevention of handgun-related injury and death, like other major public health problems, requires action at all levels of government and by all sectors of society;[30] therefore,

1. Supports the enactment of federal, state, and local laws designed to limit access to handguns,[31-33] to limit handgun purchases,[34,35] including those at gun shows,[36] to limit access to high-powered assault pistols with no legitimate sporting or hunting purpose,[37,38] and to reduce access to permits-to-carry a concealed handgun;[39-44]

2. Recommends the creation and evaluation of comprehensive national, state, and local data collection systems to facilitate research on the prevention of handgun-related fatalities and injuries and the movement of handguns within the population;[45-47]

3. Recommends regulation of the gun industry in order to reduce handgun injury attributable to industry practices, including the design, marketing, and distribution of handguns;[48-56]

4. Encourages the creation and evaluation of community- and school-based programs (including coalitions) targeting the prevention of handgun injuries including suicides, homicides, and assaults;[57]

5. Recommends education on the dangers of handguns, especially in the home for public health and mental health professionals; and

6. Recommends that health and mental health providers advise their clients about the hazards of handguns.[58-61]

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9819: The Need for Public Health Research on Gender Identity and Sexual Orientation

The American Public Health Association,

Being aware that health problems cannot be solved without adequate research that explores the behavioral, cultural, social, and etiologic aspects of the problem; and

Recognizing that the incidence and prevalence of diseases such as cancers, hepatitis B, substance abuse, suicide risk, eating disorders, HIV (human immunodeficiency virus), sexually transmitted diseases, and interpersonal

violence may be affected by sexual orientation and behavior, and gender identity;[1-10] and

Realizing that lesbians, gay men, bisexuals, and transsexual people may not see themselves at risk for many health problems and that health care providers may not identify and successfully diagnose them resulting in inadequate treatment;[11-18] and

Knowing that health problems may affect these populations differently because of economic or marital status, racial, ethnic, age, gender, place of residence and educational factors;[12,19] and

Recognizing that homophobia and discrimination against transgender populations may have adverse public health consequences; and

Concluding that educational, research, and funding institutions need to support major research initiatives to address these health problems; therefore

1. Urges funders of health research to strongly encourage their sponsored special population-based research to gather data on the sexual orientation of their populations when such data is scientifically justifiable;

2. Urges the National Institutes of Health (NIH) and the Centers for Disease Control and Prevention (CDC) to support new research initiatives to understand sexual orientation and gender identity, the prevalence and incidence of disease associated with the population, and specific health and access to care problems; and

3. Urges private and public funding agencies and educational institutions to support the development of scientists interested in doing research on sexual orientation and sexual identity issues by awarding grants to first-time researchers in the field, providing post-doctoral fellowships for research in the field, awarding funds for travel to meetings, and supporting graduate students.

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Interim Policy Statements

The following "interim policy statements" were also adopted by the Governing Council on Wednesday, November 18, 1998 during the 126th annual meeting of the American Public Health Association in Washington, DC. Introduced as "Late-Breakers," these policy statements have not been subjected to the APHA policy development process, which is designed to be open to full participation of the membership and to ensure careful review by appropriate APHA units, including reference committees, the Joint Policy Committee, APHA sections, special primary interest groups, affiliates, and others, and at public hearings during the annual meeting prior to final voting by the Governing Council. These interim policy statements are subject to that process during the ensuing year, before they can become official policy of APHA. Public Policy Statements are used as the basis of APHA's stand on legislative, legal, and regulatory issues and may stimulate scientific inquiry. They are a record of the nature, character, and values of the American Public Health Association and its membership.

98-LB-1: Modification of the Draft Healthy People 2010 Document to Recognize Older Adults
98-LB-2: Protecting Medicare Beneficiaries
98-LB-3: State and Local Preparedness for Effective Response to Bioterrorism
98-LB-4: Ensuring the Safety of the Food Supply in the United States
98-LB-5: Full Disclosure of Federal Research and Policies on Multiple Chemical Sensitivity Needed to Evaluate New Research Priorities and Policies
98-LB-6: Multi-State Tobacco Settlement
98-LB-7: International Prevention of Perinatal HIV Transmission
98-LB-8: Opposing War in the Middle East
98-LB-9: Taking Nuclear Weapons Off Alert
98-LB-10: Nuclear-Weapon-Free World

98-LB-1: Modification of the Draft Healthy People 2010 Document to Recognize Older Adults

The American Public Health Association,

Observing that America's, as well as the society of all industrialized nations is aging dramatically and this trend will accelerate significantly in the next millennium; and

Noting that life expectancy has doubled since the turn of the century and will rise to age 85 by the year 2010; and

Realizing that the 65+ population is growing at twice the rate of the under 65 population and that the age cohort of 85+ individuals, those most at risk of chronic illness, is increasing at 3X the rate of the under 65 population; and

Acknowledging that the population of adults over 65 years of age are not a homogenous group and that age cohorts of 65–74, 75–84, and 85+ individuals have very different characteristics/health needs; and

Appreciating that the future solvency of Medicare and the Social Security System is influenced heavily by the aging of society; and

Recognizing that the cost of long-term care, chronic disease and disability is often a catastrophic expense for most families; therefore

The APHA urges modification of the HP 2010 draft document such that:

(1) A work group should be established on older adults and that they be treated as a select special population;

(2) Consistent with the broad goals of Healthy People 2000 (increasing the span of healthy life, reducing health disparities among Americans and access to preventive services for all Americans) and the stated healthy People 2010 goal of increasing the quality as well as the years of healthy life; recommend that the document incorporate objectives which specifically include the following list of factors/supports that contribute to the well being, independence and functional ability of individuals/families: affordable, accessible housing; transportation; assistive technology and assistive devices; home delivered meals; respite services for care givers; financial and legal counseling; personal attendant/assistance for individuals with disabilities; and

(3) That measurable and developmental objectives should be included which: promote the concept of aging in place; expand resources for home and community based services; create a single-point-of-entry system of care; reduce elder fraud and abuse; expand preventive health benefit coverage provided by Medicare and Medicaid; improve care management.

98-LB-2: Protecting Medicare Beneficiaries

The American Public Health Association,

Noting that managed care organizations have announced this fall that, effective January 1, 1999, they will cancel or reduce the service area of more than 90 Medicare contracts, thereby dropping coverage of more than 500,000 beneficiaries in 30 states and the District of Columbia;[1–3] and

Recognizing that this has disrupted the lives of affected beneficiaries;[4] and

Recalling that Medicare beneficiaries were drawn to managed care plans by offers of broad coverage including some prescription benefits and other benefits such as preventive care, dental care, eyeglasses, and hearing aids—not available to them under either Medicare or most "Medigap" supplemental insurance options—at little or no added cost;[5] and

Knowing that the beneficiaries affected by the aforementioned contract changes will include both persons over 65 years of age and younger persons with physical or mental disabilities; and

Aware that, when the affected persons, particularly those with low incomes, seek to regain all or even some of their lost coverage via another managed care plan, many will find such coverage unavailable or unaffordable; and

Greatly concerned that millions of low income seniors and persons with disabilities are eligible for Medicaid through federal law establishing the Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), Qualified Individual (QI) Programs but experienced a series of barriers to Medicaid enrollment; and

Recognizing that affected persons who re-enroll in traditional Medicare may find that Medigap coverage, even coverage they had before enrolling in managed care, has become unaffordable; and

Noting that, whereas the Health Care Financing Administration has ruled that Medigap insurers must offer coverage (though not prescription drug coverage) to the affected persons over 65 in their service areas and may not consider their health status in determining the price, it has required neither of these protections for coverage of the affected beneficiaries under age 65 with disabilities;[6] and

Concluding that, action is needed urgently to discourage practices that throw essential benefits into uncertainty and destabilize local markets.

1. To require that low-income Medicare beneficiaries who are disenrolled from managed care plans be informed and assisted in applying for Medicaid, and that other Medi-

care beneficiaries disenrolled who re-enroll in traditional Medicare be entitled to open enrollment in the Medigap program of their choice at the premium rate they were paying when they disenrolled, or at the rate they would have paid had they enrolled in Medigap at age 65; and

2. To mandate the same protections and the same rights to purchase Medigap coverage for those beneficiaries who qualify for Medicare because of physical or mental disability as for those who qualify on the basis of age.

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98-LB-3: State and Local Preparedness for Effective Response to Bioterrorism

The American Public Health Association,

Recognizing that the potential for a bioterrorism attack directed against our civilian population represents a serious threat to this nation; and

Knowing that the possible release of smallpox, anthrax or plague into the public areas of our cities will potentially result in tens of thousands of persons dying and countless others becoming seriously ill; and

Recognizing that our public health system would be called to detect and respond to a bioterrorism event, just as we are asked to respond to conventional infectious disease outbreaks; and

Recognizing that the state and local public health infrastructure in our country is in desperate need of resources just to carry out its current duties; and

Noting that there has been inadequate support from the federal government to assist in preparation for bioterrorism; and

Aware that a comprehensive approach is necessary including a stockpile of appropriate vaccines and antibiotics in order to minimize the impact of a bioterrorism attack; therefore

1. Supports federal funding for state and local public health preparedness for bioterrorism threats among our civilian population; and

2. Urges support of coordinated federal initiatives to prepare the civilian population for a bioterrorism event.

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98-LB-4: Ensuring the Safety of the Food Supply in the United States

The American Public Health Association,

Recognizing that foods consumed by the population of the United States should be safe and wholesome; and

Recognizing that a substantial portion of the food currently consumed in the US is imported, and that the proportion of imported food in the US is increasing;[1,2] and

Recognizing that imported foods have been associated with several major outbreaks of foodborne illnesses in recent years;[3] and

Recognizing that a wide variety of foods produced in the US have also been associated with recent foodborne illness outbreaks;[4–11] and

Recognizing that many of the recent foodborne illnesses in the US are associated with emerging infectious diseases;[12] and

Recognizing that there are an estimated 6–33 million cases of foodborne illness in the US each year with up to 9,100 deaths,[13] with an annual cost for health care and of lost productivity from these illnesses of from $6.6 to $22 billion each year;[14] and

Recognizing that the rigorous application of public health principles in preventing foodborne illnesses and in controlling their spread would greatly improve the safety of the US food supply; and

Recognizing that the ability of the US government to help assure a safe food supply is compromised by the fact that authority for food safety is currently divided among some 17 federal agencies and that the legal authority which these agencies have over both domestic and foreign food sources is very limited, and that their resources for food safety assurance are very limited;[15,16] therefore

1. Recommends that all federal authority and responsibility for the safety of the US food supply be assigned to a single public health agency;

2. Recommends that the agency should be provided with sufficient scientific and enforcement resources to including food safety inspections, monitor effectively and assure the safety of the US food supply;

3. Recommends that the laws and regulations covering the safety of the US food supply should be significantly strengthened and harmonized to provide effective oversight that ensures the safety of domestic and foreign food production and contains an adequate system of penalties to ensure compliance; and

4. Recommends that research efforts designed to find better ways of assuring the safety of food designed for human consumption should be expanded with increased funding support from the federal government and other sources.

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98-LB-5: Full Disclosure of Federal Research and Policies on Multiple Chemical Sensitivity Needed to Evaluate New Research Priorities and Policies

The American Public Health Association,

Long concerned with the development of public policy and research on emerging threats to public health; and

Long concerned with chronic disorders associated with chemical exposures; and

Noting that the US federal government's Interagency Workgroup (IW) on Multiple Chemical Sensitivity (MCS) is seeking public comment on its "Predecisional Draft" of "A Report on Multiple Chemical Sensitivity";[1] and

Noting that the foreword of this report says "it provides a public health evaluation of the extent and nature of this complex problem" and that "the workgroup reviewed relevant scientific literature, ... current and past federal actions, and developed technical and policy recommendations concerning MCS;"[2] and

Recognizing that any such public health evaluation requires consideration of all relevant scientific literature and all federal actions; but

Noting that the report cites only 169 references, less than one-third of the peer reviewed literature on MCS published since 1952;[3] and

Concerned that the Predecisional Draft does not report any information about federal funds devoted to MCS-related research or conferences, with the exception of $250,000 acknowledged by Agency for Toxic Substances and Disease Registry (ATSDR) in 1993; and

Concerned that it also does not report the findings from any federally funded MCS research (again, excepting ATSDR[5]), including:

- Questionnaire data on chemical sensitivity collected by Department of Defense (DOD) from Gulf War veterans;[6]
- The results of an "informal sampling" of Department of Energy medical clinic directors about MCS;
- Studies of the prevalence of MCS and chemical sensitivity among Gulf War veterans funded by Department of Veterans Affairs;[7–9]
- Research released in 1998 by Environmental Protection Agency staff identifying MCS as the most commonly reported chronic health effect from exposure to chlorpyrifos,[10] and studies of MCS complaints associated with Sick Building Syndrome;[11–14]
- Two National Center for Environmental Health studies of still-active-duty Gulf War veterans done with the DOD that screened for chemical sensitivity, finding 5%–5.4% with MCS among the deployed compared to 2%–2.6% of controls;[15,16]
- MCS-related research that National Institute of Environmental Health Science (NIEHS) claims to have funded, comprising 53 grants totaling $10 million in 1994[17] and 88 grants totaling $13 million in 1995;[18]
- Any National Institute of Occupational Safety and Health (NIOSH) research, although it funded at least three MCS studies discussed elsewhere in the Predecisional Draft;[19–21] and

Concerned also that the IW did not consult with at least thirteen other federal authorities that already have adopted policies or funded research on MCS, including the Consumer Product Safety Commission, Department of Education, Department of Health and Human Services, Department of Housing and Urban Development, Department of Justice, Equal Employment Opportunity Commission, Federal Coordinating Council for Science, Engineering and Technology, Forest Service, National Council on Disability, National Institute on Deafness and Other Communication Disorders, National Park Service, President's Committee on Employment of People with Disabilities, and the Social Security Administration;[22] and

Concluding that the IW's public health policy and research recommendations regarding MCS cannot be fully evaluated without all the above information; therefore

Urges the Interagency Workgroup on MCS to include in its final report;

(a) a comprehensive bibliography of scientific literature on MCS;

(b) a detailed listing of all federally-funded research projects on MCS or chemical sensitivity, noting the amount of each and the results of those already published or publicly reported; and

(c) a comprehensive listing of government policies on MCS including those of federal authorities not included in the IW.

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98-LB-6: Multi-State Tobacco Settlement

The American Public Health Association,

Noting that an announcement of a proposed agreement between the tobacco industry and the state Attorneys General was made on November 16, 1998 and that the Attorneys General have only until Friday, November 20, 1998 to accept or decline on behalf of their states; and

Noting that the settlements by individual states of their lawsuits with tobacco companies have included clauses, enabling earlier-settling states to benefit from additional public health concessions contained in later state settlements; and

Recognizing that this process has resulted in significant tobacco control advances in the four states that have already settled, and promises more such advances if states continue to try or settle their cases individually; and

Concerned that a multi-state settlement would limit or terminate the process which enables earlier- settling states to benefit from later settlements, and with the likelihood that the terms of that settlement would set national tobacco control policy for the foreseeable future; and

Concerned that any multi-state settlement which does not contain air-tight restrictions against tobacco marketing that appeals to children and teenagers, or a "look-back" provision strong enough to encourage tobacco manufacturers to "de-market" their products to minors, would be grossly inadequate as tobacco control policy; and

Concerned that all monies derived from any multi-state settlement must be dedicated to smoking prevention and cessation and related public health purposes; and

Concerned that any multi-state settlement which does not require the tobacco industry to abandon its attacks on tobacco control laws and regulation is grossly inadequate; and

Recognizing that any multi-state settlement should be thoughtfully examined, analyzed, discussed and critiqued by the public health community before being accepted by Attorneys General; therefore

1. Insists that the public health community, as well as the public at large, have at least 30 days to consider the actual text of any proposed multi-state agreement before that agreement is signed by any individual state;

2. Urges state policy makers and APHA affiliates to oppose any settlement that fails to include adequately funded provisions targeted at smoking prevention and cessation and related public health programs;

3. Recommends that any such agreement not be considered acceptable if it does not provide for air-tight marketing restrictions, effective look-back provisions, and the abandonment by the tobacco industry of attacks on tobacco control laws and regulations; and

4. Urges that at least 10% of all settlement funds be allocated to state or local public health agencies for preventive public health measures.

98-LB-7: International Prevention of Perinatal HIV Transmission

The American Public Health Association,

Whereas the Joint United Nations Programme on HIV/AIDS (UNAIDS) in conjunction with United Nations Children's Fund (UNICEF) and the World Health Organization, has announced a collaborative effort to promote HIV (human immunodeficiency virus) care for women and children in low-income countries;[1] and

Whereas this effort seeks to address the devastating impact of the HIV epidemic on maternal and child populations of these countries; and

Whereas this effort comprises six components: early access to adequate prenatal care, voluntary and confidential HIV counseling and testing for women and their partners, Azothioprine (AZT) during labor and delivery for HIV infected women, improved labor and delivery care, counseling on breastfeeding options for HIV infected women, and support for women who choose not to breastfeed; and

Whereas these six components constitute a humane and principled approach to HIV care that is consistent with positions previously articulated by APHA; and

Be it resolved that the American Public Health Association supports UNAIDS' "New Initiatives to Reduce HIV Transmission from Mother-to-Child in Low-Income Countries," and empowers its leaders to take such steps as are feasible to:

- Participate in coalition efforts to ensure adequate funding from government sources and drug companies for implementation;
- Educate policy makers and the pub-

lic within the United States about the merits of this effort, and the importance of adequate funding for its implementation; and

- Foster collaboration with public health entities in low income countries to promote improved strategies for implementing the six components of the UNAIDS action plan.

Reference

1. UNAIDS, Press release: http://www.unaids.org. Geneva, June 19, 1998.

98-LB-8: Opposing War in the Middle East

The American Public Health Association,

Affirming its historic mission of promoting the public health; and

Acknowledging the catastrophic levels of disease, injury and death caused by modern warfare;[1] and

Further noting the enormous human toll in homelessness, displaced populations and destroyed food, water and sanitation capacity, all leading to further loss of life;[1-4] and

Understanding that a major underlying cause of this conflict is competition over oil reserves; and

Considering that economic conflicts on this scale are not in the interests of ordinary citizens who are sent to fight them; and

Recognizing that mortality and morbidity on a massive scale, along with staggering financial costs will result from a war; therefore

1. Herewith declares its opposition to pursuit of this war effort as an undertaking that runs counter to the health and well-being of the populations of the United States, Iraq, and the Middle East; and

2. Offers its support to the World Health Organization in providing technical and other assistance for efforts to relieve the suffering caused by earlier conflicts over the Persian Gulf region's petroleum resources.

References

1. Levy B, Sidel VW. *War and Public Health.* New York: Oxford University Press, 1996.
2. Toole MJ et al. Refugees and displaced persons. War, hunger and public health. *JAMA.* 1993;270:600–605.
3. Ascherio A, Chase R, Cote T, et al. Effect of the Gulf War on infant and child mortality in Iraq. *New Engl J Med.* 1992; 327:931–936.
4. Governing Council, American Public Health Association. Impact of Economic Embargoes on Population Health and Well-Being, Resolution passed at 1997 Annual Meeting (in press).

98-LB-9: Taking Nuclear Weapons Off Alert

The American Public Health Association,

Recalling that the Governing Council of the American Public Health Association has adopted policy statements calling for a Comprehensive Nuclear Test Ban Treaty (CTBT), an end to the continued development of nuclear weapons, and for the abolition of nuclear weapons;[1,2] and

Understanding that the public health community has long understood its inability to respond to the overwhelming casualties to be expected in the event of nuclear war; and

Noting that some 30,000 nuclear weapons remain in the world's arsenals, more than 5,000 of which, including the US and Russian arsenals, remain on hair-trigger alert; and

Recognizing that the unreliability of Russia's aging computer systems, dramatically demonstrated by problems of the Mir space station, and the apparent failure of the Russian military to address the Y2K problem as it affects these computers, makes control of Russian missiles increasingly problematic;[3] and

Understanding that the current political turmoil in Russia further increases the danger of accidental or unauthorized launch; and

Noting that a study from April 1998 published in the *New England Journal of Medicine* reported that even a limited accidental firing of such weapons could kill 6,838,000 people promptly and lead to an all out nuclear war;[4] and

Recognizing that, leading US and international military experts such as Admiral Stansfield Turner (ret), former Director of Central Intelligence, General George Lee Butler (ret), former commander of all US strategic nuclear forces, Sam Nunn, former chairman of the Senate Armed Services Committee, have for nearly 2 years been calling for urgent steps to take these weapons off hair-trigger alert;[5] therefore

1. Calls upon the President to urgently conclude an agreement with the President of Russia and other leaders of nuclear powers to take all nuclear weapons off hair-trigger alert as the next step towards the total abolition of these weapons; and

2. Requests that the President meet with a delegation from the APHA at his earliest convenience to discuss the grave danger to public health posed by maintaining nuclear missiles on alert status and the steps which must be taken to end this threat.

References

1. American Public Health Association. Resolution 8715: End to Nuclear Weapons Testing and the Strategic Defense Initiative. APHA Public Policy Statements 1948–present, cumulative. Washington, DC: American Public Health Association; current volume.
2. American Public Health Association. Resolution 9605: Cessation of Nuclear Testing and Abolition of Nuclear Weapons. APHA Policy Statements, 1948–present, cumulative. Washington, DC: American Public Health Association; current volume.
3. US Aims to Avert Y2K-Induced War. *USA Today.* November 3, 1998
4. Forrow L, et al. Accidental Nuclear War—A Post-Cold War Assessment. *N Engl J Med.* Vol 338, No 18. April 30, 1998. pp. 1328-1329.
5. Forrow L, et. al. Accidental Nuclear War-A Post-Cold War Assessment. *N Engl J Med.* Vol 338, No 18. April 30, 1998. pp. 1329.

98-LB-10: Nuclear-Weapon-Free World

The American Public Health Association,

Recalling a previous APHA policy statement calling for the abolition of nuclear weapons;[1] and

Acknowledging the action of the First Committee of the United Nations General Assembly in adopting on November 13, 1998 a policy statement entitled "Towards a Nuclear-Free-World: The Need for a New Agenda";[2] and

Recognizing that several governments that are members of NATO (North Atlantic Treaty Organization), despite intense pressure from the United States to vote against the statement, voted for the statement or abstained from voting; therefore

1. Calls upon all members of the United Nations General Assembly to vote to adopt United Nations General Assembly Resolution A/C.1/53/48/Rev.13; and

2. Calls upon the government of the United States to refrain from bringing pressure on any nation to vote against the resolution.

References

1. American Public Health Association. Resolution 9605: Cessation of Nuclear Testing and Abolition of Nuclear Weapons. APHA Policy Statements, 1948–present, cumulative. Washington, DC. American Public Health Association; current volume.
2. United Nations General Assembly Resolution A/C.1/53/48/Rev.13.